AUTHORIZATION REQUEST

Purchase of Medical Care Services
DHHS – Controller's Office

Read Instructions on Back

1. Last Name | First Name | MI

2. Patient SS #

3. Date of Birth (Month / Day / Year)

4. Sex ☐ 1. Male ☐ 2. Female

5. Race ☐ 1. White ☐ 2. Black ☐ 3. American Indian ☐ 4. Asian ☐ 5. Native Hawaiian/Other Pacific Islander ☐ 6. Unknown

Ethnicity: Hispanic or Latino Origin? ☐ Yes ☐ No ☐ Unknown

6. Preferred Language _____ Select from the list on the back of this form

7. County of Residence

8. Address | Street or RFD

9. City | State | Zip Code

10. Telephone # Home | Work

12. Program

13. Authorization Number

14. POMCS Case Number

15. Hospital or Provider of Requested Service
Contact:
Address:

Phone #:

16. Requested dates of service

17. Service is authorized for the following dates:

11. Name of Parent or Guardian or Alternate Contact | Last | First | Middle | Phone #:

18. Diagnostic Code/Diagnosis: Primary | Secondary

19. Insurance or Third Party *(Attach copies of all Insurance Cards)* | Policy # | Policyholder | Claims Address

Does this policy cover this service? ☐ Yes ☐ No Is this an HMO? ☐ Yes ☐ No **If an HMO, documentation is required. See reverse.**

20. COMPLETE FOR CANCER TREATMENT REQUESTS
A. Estimated five-year survival rate: _____%
B. Recurrent disease: ☐ Yes ☐ No If yes, attach statement about history.
C. Stage of disease or TNM classification_____
D. For Cervical Intraepithelial Neoplasia, check appropriate box: ☐ mild ☐ moderate ☐ severe

21. COMPLETE FOR ALL HIV REQUESTS
A. CD_4 Count _____
Date _____/_____/_____
B. Viral Load _____
Date_____/_____/_____

22. CHECK SERVICE REQUESTED **All programs do not cover all types of service.**
A. ☐ Inpatient Admission for _____ days
B. ☐ Inpatient Extension for _____ days
C. ☐ Outpt. (Hosp., Dial, FASC) for _____ visits
D. ☐ Physician's Office for _____ visits
E. ☐ Therapy (PT, OT, SP) Tot. #____ Freq. _____ Sess. Lgth. _____
F. ☐ Drugs related to program covered condition
G. ☐ Appliances/supplies. Give estimated cost in #23
H. ☐ Formula ____ oral ____ enteral
I. ☐ Home Nursing Care Tot. #_____ Freq. _____
J. ☐ Residential Care for _____ days
K. ☐ Nutri. Counseling Tot. #_____ Freq. _____

23. Describe service requested. Give estimated cost for **each** appliance.

24. **Ship equipment or medications to:**
Street Address: | State Rd/RFD:
City: | State: | Zip Code:

25. Enter names and addresses of providers to whom a copy of approved Authorization should be sent for billing purposes. **Do not include those listed in blocks 15 and 29.**

26A. Type or print physician's name

26B. Physician's Signature

27. Other Clinician's Signature

28. FOR ALL HIV REQUESTS
Clinician's Information:
Phone #:
Fax #:
DEA #:
NC License #:

29. Requesting Office
Agency:
Contact:
Address:

Phone #:

Date: (Month / Day / Year)

Print Reset

INSTRUCTIONS

PURPOSE

This form is used to request authorization for reimbursement from the following programs: Adult Cystic Fibrosis, Assistive Technology, Cancer Control, Children's Special Health Services, HIV Medications, Kidney and Sickle Cell. As of April 1999, the Migrant Health Program no longer requires Authorization Requests.

To qualify for payment, an applicant must be eligible for the program and an Authorization Request must be received within one year after the date of service. Processing time is reduced when this form is legible and complete. If requested, additional information must be received within one year after the date of service or within 30 days of notification, whichever is later. Incomplete forms will be returned.

Requests under Assistive Technology for Infants and Toddlers must be submitted by the third birthday. **Authorization Requests should be submitted without documentation if necessary to meet deadlines.** Requests will not be processed until all information is received.

INSTRUCTIONS FOR COMPLETING CERTAIN ITEMS ON THIS FORM

6. Select one of the following languages and enter the 2 letter code in block 6 on the front of this form.

Arabic (AR)	Gujarati (GU)	Miao (MI)	Serbo-Croatian (SC)
Cambodian (CA)	Hindi (HI)	Mon-Khmer (MK)	Spanish (SP)
Chinese (CH)	Hmong (HM)	**Other (OT)**	Tagalog (TA)
English (EN)	Hungarian (HU)	Persian (PE)	Thai (TH)
French (FR)	Italian (IT)	Poland (PO)	Urdu (UR)
French Creole (FC)	Japanese (JA)	Portuguese (PG)	Vietnamese (VI)
German (GE)	Korean (KO)	Portuguese Creole (PC)	
Greek (GR)	Laotian (LA)	Russian (RU)	

10., 15., 28., 29. Include area code with phone number.

12. Specify program applied for.

13., 17. For POMCS use only. Do not complete these items.

18. Provide ICD-9 code if available. **Diagnosis should correspond to requested service.**

19. Provide complete insurance information. Attach copies of all insurance cards. Submit HMO denial or statement of benefits **if** HMO does not cover or partially covers requested service.

20. For cancer treatment only. Do not complete for diagnostic requests.

21. For HIV Program only. Provide most recent values.

22. **All Programs Do Not Cover All Types of Service**. Refer to individual program guidelines regarding coverage limitations.

    ALL PROGRAMS
    - Use separate forms for different types of service
    - Use separate forms for each inpatient admission
    - Use separate forms for each DME provider

    CANCER CONTROL PROGRAM
    - Use separate forms for diagnostic and treatment requests
    - Designate follow up visits

23. Medical documentation is sometimes required. Refer to individual program guidelines regarding specific requirements.

24. Equipment is shipped to patient's home unless alternate address is listed here.

25. Include CAP case manager's name, address and signature if patient covered by CAP Medicaid.

26. Reserved for physician's name and signature. Cancer Control Program requires signature of attending physician. Children's Special Health Services requires original signature of program rostered physician. HIV Program allows signature of PA or Nurse Practitioner.

27. Enter signature of clinician, PA or practitioner specified by program.

28. For HIV Program, enter clinician's telephone number, fax number, DEA number and NC License number.

MAIL REQUESTS TO: Purchase of Medical Care Services
DHHS-Office of the Controller
1904 Mail Service Center
Raleigh, NC 27699-1904

Faxed Authorization Requests are not given priority. Requesting offices should contact POMCS regarding the need to expedite a request.

BILLING INSTRUCTIONS

After a service has been authorized and provided, claims should be submitted to the POMCS Claims Processing Unit, DHHS-Office of the Controller, 1904 Mail Service Center, Raleigh, NC 27699-1904. All third party payors must be billed. Providers must wait for payment or denial or wait up to six months, whichever comes first, before billing a POMCS program. **All claims must be received within one year after the date of service in order to be paid.** Additional billing information is available upon request.

HOW TO ORDER THIS FORM

Additional forms may be orderd by faxing a request to 919-733-0352 or calling 919-855-3672.

WEBSITE: www.ncdhhs.gov/control/pomcs/pomcs.htm